Exhibit 4

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

IN RE: INSULIN PRICING LITIGATION	**Case No. 2:23-md-03080 (BRM)(RLS)** **MDL No. 3080**
This document relates to: State Attorney General Track	**JUDGE BRIAN R. MARTINOTTI** **JUDGE RUKHSANAH L. SINGH**

STATE ATTORNEY GENERAL PLAINTIFF FACT SHEET

Please provide the following information for each Plaintiff that is part of the State Attorney General Track that has filed a complaint in *In Re: Insulin Pricing Litigation*, MDL No. 3080. In completing this Plaintiff Fact Sheet ("PFS"), You are under oath and must provide information that is true and correct to the best of Your knowledge, information, and belief. The scope of the questions herein and responses thereto will be limited to information and/or documents within each Your possession, custody, or control. To the extent a You lack information or documents in Your possession, custody, or control in response to the questions or document requests below, You shall expressly state You lack such information in Your response.

Do not leave any questions unanswered or blank. If You are filling out this PFS in hard copy, use additional sheets as needed to fully respond.

This PFS constitutes discovery responses subject to the Federal Rules of Civil Procedure. You must diligently investigate whether You have within Your possession, custody, or control information or documents responsive to the questions and requests, inclusive of custodial sources. (ECF No. 291 at 2.) To the extent You assert an undue burden in connection with a particular request in this PFS as to custodial files, You must meet and confer with Defendants and, if unresolved, present the issue to the Court for resolution. You may not rely on Rule 33(d) in responding to the PFS questions unless the question specifically allows production of documents in lieu of a response. You must promptly supplement Your responses if You learn that they are incomplete or inaccurate in any respect. Each question in this PFS is continuing in nature and requires supplemental answers as You obtain further information between completing this PFS and trial. Information provided will only be used for purposes related to this litigation and may be disclosed only as permitted by the Stipulated Confidentiality Order entered in this MDL proceeding. (*See* ECF No. 117.)

INSTRUCTIONS

1. None of the questions in this PFS seek privileged information. To the extent You believe that any form of privilege prevents You from fully answering a question, state Your basis

for withholding an answer or part of an answer on the grounds of privilege and which privilege You believe applies. If You assert that part of a question is objectionable or calls for privileged information, respond to the remaining parts of the question to which You do not object.

2. "And" and "or" mean "and/or" and should be construed conjunctively and disjunctively to require the broadest possible response. "Including" shall mean "including but not limited to."

3. All definitions provided herein are limited to the use of the terms in these Requests.

DEFINITIONS

1. "Administrative Fees" means any fee paid by a manufacturer to a PBM in exchange for any administrative service the PBM performs.

2. "At-Issue Products" means the insulin products and any other pharmaceuticals that You identify in response to Question No. 14.

3. "Health Plan" means all health plans offered by, administered by, or sponsored by You (including plans offered, administered, or sponsored by any State agency, department, unit, or entity) during the Period that the Health Plan offered or included Prescription Drug Coverage.

4. "Out-of-Pocket Maximum" means the maximum amount of allowable costs or expenses that a person with any form of health insurance, health coverage, prescription drug plan, or any other health plan that helps enrollees pay for prescribed pharmaceuticals can incur during a given year through their health insurance.

5. "PBM" means pharmacy benefit manager.

6. "Prescription Drug Coverage" means any form of health insurance, health coverage, prescription drug plan, Medicaid plan/program or any other health plan that helps enrollees pay for prescribed pharmaceutical drugs.

7. "Rebates" means any rebate, payment, discount, or other price concession made or paid by a manufacturer to a PBM.

8. "Third-Party Advisor" means any advisor, auditor, consultant, contractor, or other entity You contracted with, retained, or used to provide consulting, research, analysis, audits, accounting, financial advice, or other advice concerning the subject matter of this litigation, including matters related to pharmaceutical spending, the At-Issue Products, and Prescription Drug Coverage.

9. "Time Period" means January 1, 2011 to January 1, 2023.

10. "WAC" means wholesale acquisition cost.

11. "You," "Your," and "State" mean the Plaintiff named in this Action and any other State employees or entities on whose behalf the Plaintiff brings this action, including but not limited to, the Attorney General, the Attorney General's Office, the State Department of Health (or equivalent agency or department), the Department of Finance and Administration, the Department of Corrections, the State Auditor, and any other State official, department, agency, investigative unit, entity, or program.

QUESTIONS

I. CASE INFORMATION

1. Plaintiff: _____

2. Case name and caption number: _____

3. Name, firm, and e-mail of principal attorney(s) representing You: _____

4. Defendants: _____

5. Are You bringing Your complaint on behalf of any State agency in its capacity as a health insurance payor? __ Yes __ No

   If yes, in the form of the table below, identify every State agency on whose behalf You bring this complaint and the Health Plan(s) offered by the State agency ("Your Health Plan(s)"):

State Agency	Health Plan(s) Offered By Agency

6. Are You bringing Your complaint to recover for purchases made for any State-run facility?

   If yes, in the form of the table below, identify every State-run facility for which You seek to recover:

State Run Facility

7. Are You bringing Your complaint on behalf of citizens or residents of Your State (e.g., in a *parens patriae* capacity)? __ Yes __ No

   If yes, please answer all questions in Section XII ("Parens Patriae Claims") below.

8. Are You bringing Your complaint on behalf of any other person or entity not listed in Questions 5-7? __ Yes __ No

If yes, please describe the other persons or entities You bring Your complaint on behalf of:

_____

II. BENEFICIARIES

9. In the form of the table below, for each of Your Health Plan(s), provide the total number of individuals enrolled in Your Health Plan, including primary and dependent beneficiaries, for each year of the Time Period:

Year	Health Plan Identifier	Number of Beneficiaries
2011		
2012		
2013		
2014		
2015		
2016		
2017		
2018		
2019		
2020		
2021		
2022		

10. In the form of the table below, for each of Your Health Plan(s), provide the total number of individuals who used Your Health Plan to purchase or use At-Issue Products during each year of the Time Period:

Year	Health Plan Identifier	Number of Purchasers/Users of At-Issue Products
2011		
2012		
2013		
2014		
2015		
2016		
2017		
2018		
2019		
2020		
2021		
2022		

III. PERSONS OR ENTITIES WITH RELEVANT KNOWLEDGE

11. In the form of the table below, identify the name, title and department, and dates of employment of Your current and former employees, representatives, or agents who had any responsibility over the design or administration of Your Health Plan or Prescription Drug Coverage during the Time Period, including responsibility over the decision to enter into agreements governing Prescription Drug Coverage, Rebates, Your Health Plan, and formularies, and any individuals who interacted with PBMs or drug manufacturers.

Name	Title and Department	Dates of Employment or Contract	Area(s) of Responsibility (including Health Plan Identifier(s), if applicable)

12. To the extent not included in response to Question No. 11 above, in the form of the table below, identify by name, title and department, and dates of employment Your current and former employees or representatives with discoverable knowledge regarding the allegations in Your Complaint, including those individuals with knowledge or

responsibility over the State agencies and State-run facilities identified in response to Questions No. 5 and 6.

Name	Title and Department	Dates of Employment or Contract	Area(s) of Knowledge or Responsibility

13. In the form of the table below, identify by name any department, agency, subdivision, investigative unit, entity, or other program with knowledge or responsibility over functions related to the allegations in Your Complaint, including but not limited to: entities that regulate or oversee any aspect of Prescription Drug Coverage offered under Your Health Plans; entities that have any role regarding consumer spending in connection with the At-Issue Drugs; entities that communicate or contract with PBMs, drug manufacturers, or any other entities that provide rebates or other price concessions related to purchasing pharmaceutical products; and entities responsible for procuring services or products from PBMs, drug manufacturers, group purchasing organizations, or any other entities that provide or negotiate rebates or other price concessions related to purchasing pharmaceutical products. Summarize each of those entities' area of responsibility:

Entity Name	Area of Knowledge or Responsibility (including Health Plan Identifier(s), if applicable)

IV. AT-ISSUE PRODUCTS

14. Identify every insulin or other pharmaceutical that You allege is relevant to any claim for damages or other relief You seek in this case (the "At-Issue Products"):[1]

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15. In the form of the table below or through the production of documents, for each At-Issue Product, provide the total amount of money that You spent on the At-Issue Product for members enrolled in Your Health Plan for each year during the Time Period, the total Rebates received by You, and the total amount of Your members' out-of-pocket responsibility:

[1] In seeking this information, Defendants do not concede that any pharmaceuticals identified by You are relevant.

At-Issue Product	Year	Total Number of Scripts	Total Spent by You	Total Rebates Received	Your Member's Out-of-Pocket Responsibility

V. YOUR HEALTH PLANS

16. In the form of the table below, for each Health Plan that You offered that included Prescription Drug Coverage during the Time Period, identify the plan identification number, name, or other plan identifier, program type, and the starting and ending dates for each plan year during the Time Period:

Health Plan Identifier	Program Type (e.g., Medicaid, State Employer)	Start Date	End Date

17. In the form of the table below, list all PBMs or other entities with whom You have contracted to administer Prescription Drug Coverage for every Health Plan identified in response to Question No. 16 and for each plan year during the Time Period:

Health Plan Identifier	Plan Year	PBM or Other Entity

18. Identify all insurers or third-party administrators with whom You have contracted relating to the Health Plans identified in response to Question No. 16:

VI. REBATES AND FEES

19. In the form of the table below, identify each contract You have or had with a PBM during the Time Period, including the party with which You contracted, and the year. Include in Your answer any addendums or other agreements You entered pursuant to an existing master agreement. If a contract was entered into before the Time Period began but did not expire until after the Time Period began, identify that contract as well:

Contract	Contracting Entity	Year(s)

20. Have You ever used preventative drug lists, critical drug affordability programs, or any other program to lower or cap the out-of-pocket costs of the At-Issue Products for Your members? _____ Yes _____ No

If yes, in the form of the table below, identify each such Health Plan where You implemented such a program, the program, the year the program was implemented, and the applicable At-Issue Products:

Health Plan	Program	Year	At-Issue Product

21. If You implemented any program to lower or cap the out-of-pocket cost of the At-Issue Products, identify whether the program applies to the State's entire beneficiary population or only certain groups, and if only certain groups are covered please identify the groups that are covered.

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22. Identify any proposed legislation introduced during the Relevant Period that would lower or cap the out-of-pocket cost for the At-Issue Products, and whether or not that legislation was passed.

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23. Have You implemented a State Pharmaceutical Assistance Program (SPAP) or State Discount Program (SDP)? ____ Yes _____ No

If yes, in the form of the table below, identify any SPAP or SDP, the year the program was implemented, the applicable At-Issue Products, the populations covered by the program, the total number of applicants, the number of denied applicants, and the number of individuals who used the program:

SPAP/ SDP	Year	At-Issue Products	Covered Population(s)	No. of Applicants	No. of Applicants Denied	No. of Users

24. Have You ever passed Rebates received or Administrative Fees from a PBM or other contracting entity through to Your members at the point of sale for any of the At-Issue Products? _____ Yes _____ No

If yes, in the form of the table below, identify each such Health Plan where You passed on Rebates or Administrative Fees, the years You passed on Rebates or Administrative Fees, the At-Issue Products for which You passed on Rebates or Administrative Fees, and the percentage of Rebates or Administrative Fees that You passed on to members at the point of sale:

Health Plan	Year Passed on Rebate or Fee	At-Issue Product	Percentage of Rebate or Fee Passed on

25. Other than passing Rebates through to Your members at the point of sale, describe the ways in which You use Rebates and Administrative Fees received from PBMs or other contracting entities for At-Issue Products:

_____

26. In any contract identified in response to Question No. 19, did any other PBM or any other contracting entity submit bids/proposals? _____ Yes _____ No

If yes, identify any entity submitting competing bids/proposals, and produce the competing bids:

_____

27. During the relevant time period, did You contract with, or use master contracts from, any other entities (e.g., MMCAP) for Rebates, fees, or other price concessions related to purchasing pharmaceutical products? _____ Yes _____ No

If yes, in the form of the table below, identify each such contract, the contracting entity, the year, and the percentage of or other determinant of the Rebates, fees, or price concessions the contracting entity agreed to pass through to You:

Contract	Contracting Entity	Year	Percentage of Rebates

VII. MEDICAID PROGRAMS

28. If You assert Medicaid claims, identify every medical insurance plan or carrier used by your State Medicaid program during the Relevant Time Period. For each, please provide the following information:

Name	Dates Offered	Plan's Pharmacy Benefit Manager / Claims Processor

29. If You asserted Medicaid claims, identify every Pharmacy Benefit Manager and other third-party administrator used by your State Medicaid program since January 1, 2011. For each response, please provide the following information:

Name	Relevant Dates	Name and Title of Individuals Who Oversaw Program

30. Are You asserting claims or seeking recoveries relating in any way to Medicaid benefits that are offered, administrated, and/or funded your State? __ Yes __ No

If yes, in the form of the table below, identify every State Medicaid plan or program offered during the Relevant Time Period. For each, please provide the following information:

Name of Medicaid Plan or Program	Delivery System (FFS, MCO, PCCM, limited benefit)	Dates Offered	Entity Responsible for Plan Administration

31. If You answered yes to Question No. 30, identify every Pharmacy Benefit Manager and other third-party administrator used by your State Medicaid program since January 1, 2011. For each response, please provide the following information:

Name of PBM or Third-Party Administrator	Relevant Dates	Name of Medicaid Plan or Program

32. Have You adopted the Affordable Care Act's Medicaid expansion?____ Yes _____ No

33. If You answered yes to Question No. 32, have You made eligibility for Medicaid expansion programs contingent on waivers with eligibility conditions, including, but not limited to, requirements that participants work a certain number of hours per week, that differ from what is required by the Affordable Care Act? ____ Yes _____ No

VIII. MISREPRESENTATIONS AND OMISSIONS

34. In the form of the table below, identify every specific misrepresentation that a Defendant allegedly made that forms the basis of the allegations in Your lawsuit, of which You are currently aware, including the approximate date, the source, who received the statement, the reason why You believe the statement was false, whether or not You relied on the statement, and if so, how, and the Defendant(s) that made the statement:

Misrepre-sentation	Approx. Date	Source	Recipient	Basis that Statement is False	Reliance (if any)	Defendant(s)

35. In the form of the table below, describe any omissions that a Defendant allegedly made that forms the basis of the allegations in Your lawsuit, of which You are currently aware, including the approximate date, any statement to which the omission relates, the reason why You believe a Defendant should have disclosed the omission, and the Defendant(s) that made the omission:

Omission	Approximate Date	Related Statement	Basis for Disclosure	Defendant(s)

36. In the form of the table below, identify each and every WAC, list price, or other pricing figure that you allege is or was artificially inflated, false, fraudulent, misleading, or that otherwise forms the basis for the allegations in Your lawsuit, of which You are currently aware, including the approximate date the pricing figure was published or reported, the Defendant that published or reported the pricing figure, and a description of what You allege each WAC, list price, or other pricing figure should have been absent the allegedly wrongful conduct.

Pricing Figure	Approximate Date	Defendant(s)	What You Allege Pricing Figure Should Have Been

IX. TIMING OF AWARENESS

37. Identify when and how You first learned or discovered that the prices for the At-Issue Products were allegedly artificially inflated, false, fraudulent, misleading, or deceptive:

_____

38. Identify the earliest date on which You began investigating the pricing of Defendants' At-Issue Products for the purpose of bringing the present action:

_____

39. Identify all legal actions, investigations, or proceedings that were taken or initiated by You concerning the pricing of Defendants' At-Issue Products, including all investigations by Your State Attorney General, and the date on which they were first initiated:

_____

40. Identify when You first learned or discovered that Defendants' statements about the prices for the At-Issue Products were allegedly false, fraudulent, misleading, or deceptive:

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41. Describe how You first learned or discovered that Defendants' statements about the prices for the At-Issue Products were allegedly false, fraudulent, misleading, or deceptive:

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42. Identify when and how You learned of or discovered the *In re Insulin Pricing* (D.N.J., 2:17-cv-00699) lawsuit, including whether a copy of that complaint that was sent to You by the plaintiffs in that matter:

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43. Identify when and how You learned of or discovered any other lawsuit filed against any Defendant related to insulin pricing, including *MSP LLC* (D.N.J., 2:18-cv-02211), *Minnesota* (D.N.J., 2:18-cv-14999), and *In re Direct Purchaser Insulin Pricing Litigation* (D.N.J., 3:20-cv-03426):

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44. Identify when and how You learned of or discovered any state, or federal investigation related to insulin pricing:

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45. Identify the earliest date on which You became aware of any patient assistance programs offered by the manufacturer Defendants:

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46. Identify the earliest date on which You became aware of any program offered by any PBM capping the monthly out-of-pocket cost for any At-Issue Drug (e.g., Express Scripts Patient Assurance Program):

X. SELECTION OF PRESCRIPTION DRUG COVERAGE

47. In the form of the table below, identify any third-party services, advisors, consultants, or contractors used by You to provide consulting, research, analysis, accounting, financial advice, solicitation, selection, development, or other advice related to each of Your Health Plan(s), selecting or soliciting PBM services, or Prescription Drug Coverage for At-Issue Products during the Time Period, the approximate dates You used the third-party services, advisors, consultants, or contractors, a description of the services that entity provided You,

and the principal point of contact at the entity who is or was responsible for overseeing performance of the contract:

Third-Party Advisor (Advisor Name and Employer)	Approximate Dates	Description of Services	Point of Contact

48. For each third-party service, advisor, consultant, or contractor You identified in Question No. 46, in the form of the table below or through the production of documents, identify whether You received any presentations, reports, analyses, or memoranda related to Health Plans or Prescription Drug Coverage benefits designed for At-Issue Products, and produce those materials:

Third-Party Advisor	Received Presentations, Reports, Analyses, Memoranda (Yes/No)

49. Did You or anyone acting on Your behalf conduct a request for proposal ("RFP") or similar process to solicit offers from or to otherwise identify PBMs to administer Prescription Drug Coverage? _____ Yes _____ No

If yes, in the form of the table below, identify each RFP or other solicitation You made during the Time Period, any third-party advisor that assisted with the RFP or solicitation, the PBMs You sent the RFP or solicitation to, and produce the RFP responses:

RFP or Solicitation	Third-Party Advisor	Date	PBMs Solicited

50. Are Your Health Plan or Medicaid expenditures related to pharmaceuticals audited, either internally or by an external auditor? _____ Yes _____ No

If yes, in the form of the table below, identify each audit and produce the audit:

Audit	Person or Entity conducting the Audit	Date	Purpose of the audit

XI. MEMBERSHIP IN OTHER ENTITIES

51. In the form of the table below, identify any organizations that You are a part of that share information regarding at-issue insulins, pharmaceutical pricing, Rebates, PBM or drug pricing reform or legislation, including, but not limited to, MMCAP or any other group

purchasing organization, and identify any of Your employees who are involved in that organization:

Organization	Dates of Membership	Your Involved Employees

XII. *PARENS PATRIAE* CLAIMS

52. What sovereign or quasi-sovereign interest(s) do you allege are being advanced by this lawsuit?

_____

53. Identify below each citizen of your State You intend to use to support Your claims or defenses in this lawsuit.

Name	Address	Contact Information

54. In the form of the table below, identify any third-party advisors used by You to provide consulting or other advice related to out-of-pocket costs incurred by Your citizens in relation to the At-Issue Products in Your State during the Time Period, the approximate dates You used the third-party services, a description of the services that entity provided You, and the principal point of contact at the entity who is or was responsible for overseeing performance of the contract:

Third-Party Advisor (Advisor Name and Employer)	Approximate Dates	Description of Services	Point of Contact

55. Identify any task force, study, working group, initiative, or other investigatory body related to the cost of pharmaceutical products, including the At-Issue drugs, created by You or in which You participated, and provide the dates of operation and a description of same.

Task Force, Study, Working Group, or Other Initiative	Approximate Dates of Operation	Description of Operations and Objective(s)

56. Have You received any complaints about the cost of pharmaceutical products in Your state? _____ Yes _____ No

If yes, in the table below or through the production of documents, identify from whom You received the complaint, the approximate date of the complaint, the substance of the complaint, and Your response, if any.

Source of Complaint	Approximate Date of Complaint	Substance of Complaint	Your Response to Complaint

57. Do You offer any assistance programs specifically pertaining to Your citizens with pre-diabetes or diabetes? _____ Yes _____ No

If yes, in the table below, identify the assistance program, the year(s) it was offered, the department, agency, third-party, or other entity that provided it, and provide a summary of the program.

Program Name	Year(s) Offered	Entity Offering the Program	Summary of Program

58. In the table below, identify the out-of-pocket costs paid by Your citizens in connection with the At-Issue Products for each year:

At-Issue Product	Year	Total Spent by Your Citizens

XIII. DIRECT PURCHASING

59. Have You purchased At-Issue Products directly from pharmaceutical manufacturers, wholesalers, mail order pharmacies, and/or retail sellers? ____ Yes _____ No

If yes, in the table below, identify each At-Issue Product You allege You purchased directly, the specific years You made the direct purchase, the entity that directly distributed the At-Issue Product(s) to You, the total quantity of At-Issue Products You purchased, and the total amount You paid:

At-Issue Product	Year	Direct Seller	Total Quantity	Total Amount Paid

XIV. DAMAGES AND OTHER RELIEF

60. For what period of time are You alleging damages?

_____

61. For each Defendant identified in Question No. 4, state how You claim You, or Your residents, have been harmed by that Defendant's alleged conduct and identify the date when You allege that You were first injured as a result of that particular Defendant's alleged conduct. This request is not designed to require an expert evaluation:

Defendant	Basis	Date

62. Are you seeking any damages on behalf of your citizens on a *parens patriae* basis?

_____ Yes _____ No

If yes, summarize the categories of damages or monetary relief that You allege:

_____

63. Are You seeking any monetary relief based on an injury to the State itself? _____ Yes _____ No

If yes, summarize the categories of damages or monetary relief that You allege:

_____

64. Are You seeking any injunctive relief? _____ Yes _____ No

If yes, in the table below, identify the conduct you seek to enjoin as to each defendant, and the basis for such:

Defendant	Conduct To Be Enjoined	Basis

65. Are You seeking any remedy not covered by Questions No. 60-64 above?

_____ Yes _____ No

If yes, identify each remedy that You seek:

_____

INITIAL DOCUMENT REQUESTS

Please produce the following documents for the Time Period:

1. Each RFP seeking PBM services, including all amendments, riders, schedules, supplements, instructions, or other addenda that You issued during the Time Period.

2. Documents, including internal summaries, analyses, and presentations, reflecting Your reasons for selecting or not selecting a PBM prescription drug benefit plan for each year, including bids, communications, RFPs, procurement rules, guidance documents, and related documents, and documents relating to negotiation for Rebates for Your employee plan(s) or for Medicaid.

3. Each contract, including amendments, riders, schedules, supplements, or other addenda that You entered into with a PBM, health insurer, third-party administrator, or any other entity through which You obtained price concessions during the Time Period (e.g., MMCAP), or that otherwise was in effect during the Time Period.

4. Documents sufficient to identify the formularies for Your Health Plans during the Time Period.

5. For each benefit year for which You are seeking relief, documents relating to Your Health Plans, including documents sufficient to show: (1) the annual deductible(s), including separate deductible amounts or requirements for use of in-network versus out-of-network pharmacies, and any separate deductible amounts or requirements on individual versus family expenditures, (2) the copayment or coinsurance rate for each pharmaceutical tier, (3) the annual Out-of-Pocket Maximums, (4) the summary plan description, and (5) summaries of benefits and coverage associated with each of Your Health Plans during the time period.

6. Documents received by You that related to representations made by PBMs about their services or made by pharmaceutical manufacturers about their list prices.

7. Contracts with third-party advisors or auditors in effect during the Time Period that relate to prescription drug benefits, as well as any presentations, reports, analyses, or memoranda relating to prescription drug benefits Plaintiffs chose or did not choose.

8. Documents or communications relating to Patient Assistance Programs offered by You, by Defendants, or by another entity.

9. Documents relating to any study or analysis conducted or commissioned by You during the relevant time period that relates to Your population of diabetic citizens or considers whether consumers should pay for insulin, and if so, how much consumers should pay.

CERTIFICATION

I declare under penalty of perjury that all of the information provided in this PFS is complete, true, and correct to the best of my knowledge and information, and that I have provided all of the requested documents that are reasonably accessible to me and/or my attorneys, to the best of my knowledge.

Signature	Date
Name (Printed)	Title